STATEMENT OF EMERGENCY

907 KAR 1:604E

(1) This emergency administrative regulation is being promulgated to alter the Department for Medicaid Services (DMS) copayment policies. Under this emergency administrative regulation, Medicaid members, except for individuals in an optional eligibility group, shall be required to pay one (1) dollar for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; two (2) dollars for each brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; three (3) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy. Medicaid members in an optional eligibility group shall be required to pay one (3) dollars for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; ten (10) dollars for each brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; twenty (20) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy. Additionally, all Medicaid members shall be required to pay two (2) dollars for each visit to a physician's office; three (3) dollars for each outpatient hospital service or visit to an emergency room for a non-emergency service; and fifty (50) dollars for each admission to a hospital for inpatient hospital services. This action must be taken on an emergency basis to ensure the viability of the Medicaid program and to best utilize the program's resources in serving the health, safety and welfare needs of Medicaid recipients.

(2) Failure to enact this administrative regulation on an emergency basis would pose an imminent threat to the public health, safety or welfare of Medicaid recipients whose receipt of services may be jeopardized due to a lack of funding or provider accessibility.

(3) This emergency administrative regulation shall be replaced by an identical ordinary administrative regulation filed with the Regulations Compiler.

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Ernie Fletcher
Governor

_____

James W. Holsinger, Jr., M.D., Secretary
Cabinet for Health and Family Services

CABINET FOR HEALTH AND FAMILY SERVICES

Department for Medicaid Services

Office of the Commissioner

(Emergency Amendment)

907 KAR 1:604E. Recipient cost-sharing.

RELATES TO: KRS 205.560, 205.6312, 205.6485, 42 C.F.R. 430.10, 431.51, 447.15, 447.21, 447.50, 447.52, 447.53, 447.54, 447.59, 457.224, 457.505, 457.510, 457.515, 457.520, 457.530, 457.570, 42 U.S.C. 1396a, b, c, d, o, r-6, r-8, HB 267 of the 2005 Session of the General Assembly

STATUTORY AUTHORITY: KRS 194A.030(2), 194A.050(1), 205.520(3), 205.6312(5), 205.6485(1), 42 C.F.R. 431.51, 447.15, 447.51, 447.53, 447.54, 447.55, 447.57, 457.535, 457.560, 42 U.S.C. 1396r-6(b)(5)[, EO 2004-726]

NECESSITY, FUNCTION, AND CONFORMITY: [EO 2004-726, effective July 9, 2004, reorganized the Cabinet for Health Services and placed the Department for Medicaid Services and the Medicaid Program under the Cabinet for Health and Family Services.] The Cabinet for Health and Family Services, Department for Medicaid Services has responsibility to administer the Medicaid Program. KRS 205.520(3) authorizes the cabinet, by administrative regulation, to comply with any requirement that may be imposed, or opportunity presented, by federal law for the provision of medical assistance to Kentucky's indigent citizenry. KRS 205.6312(5) requires the cabinet to promulgate administrative regulations that implement copayments or other similar

charges for Medicaid recipients. KRS 205.6485(1) requires the cabinet to establish, by administrative regulation, premiums for families with children in the Kentucky Children's Health Insurance Program. 42 U.S.C. 1396r-6(b)(5) allows for a monthly premium in the second six (6) months of transitional medical assistance. This administrative regulation establishes the provisions relating to imposing and collecting copayments and premiums from certain recipients.

Section 1. Definitions.

(1) "Copayment" means that portion of the cost of a Medicaid service that a recipient is required to pay.

(2) "Department" means the Department for Medicaid Services or its designee.

(3) "Drug" means a covered drug provided in accordance with 907 KAR 1:019 for which the Department for Medicaid Services provides reimbursement.

(4) "General ophthalmological service" means a service or procedure listed under this heading in the American Medical Association's Current Procedure Terminology (CPT).

(5) "Long-term care facility" is defined by KRS 216.510(1).

(6) "KCHIP" means the Kentucky Children's Health Insurance Program.

(7) "KCHIP Separate Insurance Program" means a health benefit program for individuals with eligibility determined in accordance with 907 KAR 4:030, Section 2.

(8) <u>“Non-emergency service” means a service that does not meet emergency service criteria as established in 42 CFR 447.53.</u>

<u>(9) “Optional eligibility group” means a group or group not identified in Social Security Act 1902(a) as a mandatory group or a group established as optional pursuant</u>

to Social Security Act 1902(a) or Social Security Act 1905(a).

(10) "Premium" means an amount paid periodically to purchase health care benefits.

(11) [~~(9)~~] "Recipient" means an individual who has been determined eligible to receive benefits under the state's Title XIX or Title XXI program in accordance with 907 KAR Chapters 1 through 4.

(12) [~~(10)~~] "Transitional medical assistance" or "TMA" means an extension of Medicaid benefits for up to twelve (12) months for families who lose Medicaid eligibility solely because of increased earnings or hours of employment of the caretaker relative or loss of earning disregards in accordance with 907 KAR 1:011, Section 5(8)(b).

Section 2. Copayment Amounts and Exclusions.

(1) Except as excluded in subsection (4) or (5) of this section, the department shall require a recipient to make a copayment for:

(a) Each drug dispensed by a dispensing pharmacy;

(b) A service provided by:

1. An audiologist;

2. A chiropractor;

3. A dentist;

4. A hearing aid dealer;

5. An optician;

6. A podiatrist; [~~or~~]

(c) A general ophthalmological service provided by:

1. A physician;

2. An advanced registered nurse practitioner;

3. A primary care center or federally qualified health center;

4. A rural health clinic; [~~or~~]

5. An optometrist;

(d) Each visit to a physician's office;

(e) An outpatient hospital service provided in accordance with 907 KAR 1:014;

(f) Each visit to an emergency room for a non-emergency service; or

(g) An inpatient hospital admission pursuant to 907 KAR 1:012.

(2) The amount of the required copayment shall be:

(a) Except for an individual in an optional eligibility group, one (1) dollar for each:

1. Generic drug dispensed by a dispensing pharmacy; or

2. Atypical antipsychotic drug dispensed by a dispensing pharmacy if the atypical antipsychotic drug does not have a generic equivalent;

(b) Except for an individual in an optional eligibility group, two (2) dollars for each brand name drug dispensed by a dispensing pharmacy if the brand name drug:

1. Does not have a generic equivalent; and

2. Is available under the supplemental rebate program;

(c) Except for an individual in an optional eligibility group, three (3) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy;

(d) Effective August 1, 2005:

1. Two (2) dollars per recipient, per provider, per date of service for a:

a. Visit to a physician's office; or

b. Service identified in subsection (1)(b) or (c) of this section;

2. Three (3) dollars per recipient, per provider, per date of service for a:

a. Covered outpatient hospital service provided in accordance with 907 KAR 1:014; or

b. Visit to an emergency room for a non-emergency service;

3. Fifty (50) dollars per recipient, per provider, per date of service for each covered admission to a hospital for inpatient hospital services provided in accordance with 907 KAR 1:012;

(e) Effective July 15, 2005, three (3) dollars for each:

a. Generic drug dispensed by a dispensing pharmacy to an individual in an optional eligibility group; or

b. Atypical antipsychotic drug dispensed by a dispensing pharmacy to an individual in an optional eligibility group if the atypical antipsychotic drug does not have a generic equivalent;

5. Ten (10) dollars for each brand name drug dispensed by a dispensing pharmacy to an individual in an optional eligibility group if the brand name drug:

a. Does not have a generic equivalent; and

b. Is available under the supplemental rebate program; or

6. Twenty (20) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy to an individual in an optional eligibility group.

(3) For each prescription or service for which a copayment is required, the department shall reduce provider reimbursement as follows:

(a) Except for a drug provided to an individual in an optional eligibility group, one (1) dollar from the dispensing fee for a drug dispensed by a dispensing pharmacy;

(b) Two (2) dollars from reimbursement for a service identified in subsection (1)(b) or (c) of this section;

(c) Three (3) dollars from reimbursement:

a. For a covered outpatient hospital service as identified in subsection (1)(e)1. of this section; or

b. For a drug identified in subsection (2)(d)4 of this section;

(d) Ten (10) dollars from reimbursement for a drug identified in subsection (2)(d)5 of this section;

(e) Twenty (20) dollars from reimbursement for a drug identified in subsection (2)(d)6; or

(f) Fifty (50) dollars from reimbursement for each covered admission to a hospital for inpatient hospital services as identified in subsection (1)(g).

[~~(2) The amount of the required copayment shall be:~~

~~(a) One (1) dollar for each drug dispensed by a dispensing pharmacy; or~~

~~(b) Two (2) dollars per recipient, per provider, per date of service for a service identified in subsection (1)(b) or (c) of this section.~~

~~(3) The department shall reduce by the amount of the required copayment:~~

~~(a) A dispensing fee for a service identified in subsection (1)(a) of this section;~~ ~~and~~

~~(b) Reimbursement for a service identified in subsection (1)(b) or (c) of this section.~~]

(4) The department shall not require a copayment and a provider shall not collect a copayment from a recipient for:

(a) A service excluded in accordance with KRS 205.6312;

(b) A service provided to a recipient who has reached his or her 18th birthday but has not turned nineteen (19) and who is:

1. In the custody of the state; and

2. In a foster home or residential placement facility; or

(c) A service provided to a recipient residing in a long-term care facility.

(5) The department shall not require a copayment and a provider shall not collect a copayment in accordance with the exclusions established in 42 U.S.C. 1396o and 42 CFR 447.53.

(6) [~~(a)~~] Unless excluded in subsection (4) or (5) of this section, the department has determined that each Medicaid recipient:

1. Should be able to pay a required copayment; and

2. Shall be responsible for a copayment.

[~~(b) The department shall indicate on a recipient's Medical Assistance Identification card if the recipient is responsible for a copayment.~~]

(7) [~~(6)~~] The department shall not increase its reimbursement to a provider to offset an uncollected copayment from a recipient.

Section 3. Provisions for Collection of Copayments.

(1) A provider shall collect a copayment from a recipient in an amount and for a service described in Section 2(1) and (2) of this administrative regulation.

(2) A provider may collect the copayment at the time a service is provided or at a later date.

(3) A provider shall not refuse to provide a service if a recipient is unable to pay a

required copayment. This provision shall not:

(a) Relieve a recipient of an obligation to pay a copayment; or

(b) Prevent a provider from attempting to collect a copayment.

(4) If it is the routine business practice of a provider to terminate future services to an individual with uncollected debt, the provider may include uncollected copayments under this practice.

(5) A provider shall give advanced notice to a recipient with uncollected debt before services can be terminated.

(6) A provider shall not waive a copayment obligation as imposed by the department for a recipient.

(7) A pharmacy provider or supplier, including a pharmaceutical manufacturer as defined in 42 U.S.C. 1396R-8(k)(5), or a representative, employee, independent contractor or agent of a pharmaceutical manufacturer, shall not make a copayment for a recipient.

(8) A parent or guardian shall be responsible for a copayment imposed on a dependent child under the age of twenty-one (21).

Section 4. Premiums for KCHIP Separate Insurance Program Recipients.

(1) The department shall require a family with children participating in the KCHIP Separate Insurance Program to pay a premium of twenty (20) dollars per family, per month.

(2)(a) The family of a new KCHIP Separate Insurance Program eligible shall be required to pay a premium beginning with the first full month of benefits after the month of application.

(b) Benefits shall be effective with the date of application if the premium specified in paragraph (a) of this subsection has been paid.

(3) Retroactive eligibility as described in 907 KAR 1:605, Section 2(3), shall not apply to a recipient participating in the KCHIP Separate Insurance Program.

(4)(a) If a family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the first benefit month for which the premium has not been paid.

(b)1. A KCHIP Separate Insurance Program recipient shall be eligible for reenrollment upon payment of the missed premium.

2. If twelve (12) months have elapsed since a missed premium, a KCHIP Separate Insurance Program recipient shall not be required to pay the missed premium before reenrolling.

Section 5. Premiums for Transitional Medical Assistance Recipients.

(1) The department shall require a family receiving a second six (6) months of TMA, whose monthly countable earned income is greater than 100 percent of the federal poverty limit, to pay a premium of thirty (30) dollars per family, per month.

(2) If a TMA family fails to make two (2) consecutive premium payments, benefits shall be discontinued at the end of the benefit month for which the premium has not been paid unless the family has established to the satisfaction of the department that good cause existed for failure to pay the premium on a timely basis. Good cause shall exist under the following circumstances:

(a) An immediate family member living in the home was institutionalized or died during the payment month;

(b) The family was victim of a natural disaster including flood, storm, earthquake, or serious fire;

(c) The caretaker relative was out of town for the payment month; or

(d) The family moved and reported the move timely, but the move resulted in:

1. A delay in receiving the billing notice; or

2. Failure to receive the billing notice.

Section 6. Notices and Collection of Premiums.

(1) Premiums shall be collected in the amounts and from the recipients described in Sections 4 and 5 of this administrative regulation.

(2) The department shall give advance notice of the:

(a) Premium amount; and

(b) Date the premium is due.

(3) To continue to receive benefits, a family shall pay a premium:

(a) In full; and

(b) In advance.

(4) If a family pays the required premiums semiannually or quarterly in advance, they shall receive a ten (10) percent discount.

Section 7. Cumulative Cost-sharing Maximum.

(1) Cumulative cost sharing for premium payments and copayments for a family with children who receive benefits under Title XXI, 42 U.S.C. 1397aa to 1397jj, shall be limited to five (5) percent of annual family income.

(2) A monthly premium for a family who receives benefits under 42 U.S.C. 1396r-6(b) shall not exceed three (3) percent of the average gross monthly income less the

average monthly costs of child care necessary for the employment of the caretaker relative.

Section 8. Provisions for Recipients in Medicaid-Managed Care.

(1) If a copayment is imposed on a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705, it shall be in accordance with the limitations and provisions established in this administrative regulation.

(2) The premium provisions pursuant to Sections 4 and 5 of this administrative regulation shall apply to a recipient receiving services through a managed-care entity operating in accordance with 907 KAR 1:705.

(3) A six (6) month guarantee of eligibility as described in 907 KAR 1:705, Section 3(6) shall not apply to a recipient required to pay a premium pursuant to Section 4 of this administrative regulation.

Section 9. Freedom of Choice. In accordance with 42 C.F.R. 431.51, a recipient may obtain services from any qualified provider who is willing to provide services to that particular recipient.

Section 10. Notice of Discontinuance, Hearings, and Appeal Rights.

(1) The department shall give notice of, and an opportunity to pay, past due premiums prior to discontinuance of benefits for nonpayment of a premium.

(2)(a) If a family's income has declined, the family shall submit documentation showing the decline in income.

(b) Following receipt of the documentation, the department shall determine if the family is required to pay the premiums established in Section 4 or 5 of this

administrative regulation using the new income level.

(c) If the family is required to pay the premium and the premium has not been paid, the benefits shall be discontinued in accordance with Section 4(4)(a) or 5(2) of this administrative regulation.

(d) If the family is not required to pay the premium, benefits shall be continued under an appropriate eligibility category.

(3) The department shall provide the recipient with an opportunity for a hearing in accordance with 907 KAR 1:560 upon discontinuing benefits for nonpayment of premiums.

(4) An appeal of a department decision regarding the Medicaid eligibility of an individual shall be in accordance with 907 KAR 1:560.

907 KAR 1:604E

REVIEWED:

Date	Shannon Turner, J.D., Commissioner Department for Medicaid Services
Date	Mike Burnside Undersecretary for Administration and Fiscal Affairs

APPROVED:

Date	James. W. Holsinger, Jr., M.D., Secretary Cabinet for Health and Family Services

REGULATORY IMPACT ANALYSIS
AND TIERING STATEMENT

Administrative Regulation #: 907 KAR 1:604E
Cabinet for Health and Family Services
Department for Medicaid Services
Agency Contact Person: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

(1) Provide a brief summary of:
(a) What this administrative regulation does: This administrative regulation establishes the provisions relating to imposing and collecting copayments and premiums from certain Medicaid recipients.
(b) The necessity of this administrative regulation: This administrative regulation is necessary to establish copayments or other similar charges for Medicaid recipients. This administrative regulation is also necessary to establish premiums for families with children in the Kentucky Children's Health Insurance Program.
(c) How this administrative regulation conforms to the content of the authorizing statutes: This administrative regulation conforms to the content of KRS 205.6312(5) by establishing copayments or similar charges to be paid by Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o. This administrative regulation conforms to the content of KRS 205.6485(1) by establishing the premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program.
(d) How this administrative regulation currently assists or will assist in the effective administration of the statutes: This administrative regulation currently assists and will continue to assist in the effective administration of the authorizing statutes by establishing the provisions relating to imposing and collecting copayments and premiums from certain Medicaid recipients.

(2) If this is an amendment to an existing administrative regulation, provide a brief summary of:
(a) How the amendment will change this existing administrative regulation: The amendment establishes the Department for Medicaid Services (DMS) copayment policies as follows:
Medicaid members, except for individuals in an optional eligibility group, shall be required to pay one (1) dollar for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; two (2) dollars for each brand name drug that does not have a generic equivalent and is available under the supplemental rebate program; three (3) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy.
Medicaid members in an optional eligibility group shall be required to pay one (3) dollars for each generic drug or atypical antipsychotic drug that does not have a generic equivalent; ten (10) dollars for each brand name drug that does not have a generic equivalent and is available under the supplemental

rebate program; twenty (20) dollars for each non-preferred brand name drug dispensed by a dispensing pharmacy. Additionally, all Medicaid members shall be required to pay two (2) dollars for each visit to a physician's office; three (3) dollars for each outpatient hospital service or visit to an emergency room for a non-emergency service; and fifty (50) dollars for each admission to a hospital for inpatient hospital services. Copayment exclusions exist in accordance with 42 U.S.C. 1396o and 42 CFR 447.53.

(b) The necessity of the amendment to this administrative regulation: The amendment to this administrative regulation is necessary to maintain the financial viability of the Department for Medicaid Services.

(c) How the amendment conforms to the content of the authorizing statutes: The amendment to this administrative regulation conforms to the content of the authorizing statutes, including HB 267 of the 2005 Session of the General Assembly, by establishing copayments to be paid by Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o.

(d) How the amendment will assist in the effective administration of the statutes: The amendment to this administrative regulation will assist in the effective administration of the authorizing statutes by establishing provisions relating to imposing and collecting copayments from certain Medicaid recipients.

(3) List the type and number of individuals, businesses, organizations, or state and local government affected by this administrative regulation: Medicaid recipients, outpatient pharmacy providers, physicians, and hospitals will be affected by this administrative regulation.

(4) Provide an assessment of how the above group or groups will be impacted by either the implementation of this administrative regulation, if new, or by the change if it is an amendment: Prior to the amendment, Medicaid recipients paid a one (1) dollar copayment for all prescriptions and two (2) dollars for each general ophthalmological service or each service provided by an audiologist, chiropractor, dentist, hearing aid dealer, optician, or podiatrist. The amendment increases copayment amounts for some prescription drugs, depending on the category and depending on whether an individual is in an optional eligibility group, and implements copayments designated services. DMS believes these policies will promote recipient understanding of the cost of medical assistance and encourage responsible utilization. Providers are expected to collect designated copayments from Medicaid recipients.

(5) Provide an estimate of how much it will cost to implement this administrative regulation:

(a) Initially: The Department anticipates an expenditure reduction of $21.6 million ($15 million in federal funds and $6.6 million in state matching funds) for state fiscal year (SFY) 2006. The anticipated total savings breaks down for each category as follows: a decrease of $10 million for prescription drugs; a decrease of $5 million for emergency room visits; a decrease of $3 million for

physician office visits; a decrease of $2.5 million for inpatient hospital services; and a decrease of $1.1 million for outpatient hospital services.

(b) On a continuing basis: DMS is unable at this time to estimate the anticipated expenditure reductions on a continuing basis.

(6) What is the source of the funding to be used for the implementation and enforcement of this administrative regulation: Federal funds authorized under the Social Security Act, Title XIX, and matching funds of general fund appropriations and collections will be used to fund the implementation and enforcement of this administrative regulation.

(7) Provide an assessment of whether an increase in fees or funding will be necessary to implement this administrative regulation, if new, or by the change if it is an amendment: Neither an increase in fees nor funding will be necessary to implement this administrative regulation. However, an increase in designated copayment amounts is necessary to implement this administrative regulation.

(8) State whether or not this administrative regulation establishes any fees or directly or indirectly increases any fees: This administrative regulation neither establishes nor increases any fees. However, this administrative regulation establishes provisions relating to imposing and collecting copayments and premiums from certain recipients.

(9) Tiering: Is tiering applied? (Explain why tiering was or was not used)

Tiering was not appropriate in this administrative regulation because the administrative regulation applies equally to all those individuals or entities regulated by it. Disparate treatment of any person or entity subject to this administrative regulation could raise questions of arbitrary action on the part of the agency. The “equal protection” and “due process” clauses of the Fourteenth Amendment of the U.S. Constitution may be implicated as well as Sections 2 and 3 of the Kentucky Constitution.

FEDERAL MANDATE ANALYSIS COMPARISON

Reg. No. 907 KAR 1:604E

Agency Contact: Stuart Owen or Stephanie Brammer-Barnes (564-6204)

1. Federal statute or regulation constituting the federal mandate.

   Pursuant to 42 USC 1396a et. seq., the Commonwealth of Kentucky has exercised the option to establish a Medicaid Program for indigent Kentuckians. Having elected to offer Medicaid coverage, the state must comply with federal requirements contained in 42 USC 1396 et. seq.

   This administrative regulation complies with federal statutes/regulations governing the Medicaid program and recipient cost sharing.

2. State compliance standards.

   This administrative regulation complies with KRS 205.6312(5) by establishing copayments or similar charges to be paid by Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o. This administrative regulation complies with KRS 205.6485(1) by establishing the premium contribution per family of health insurance coverage available under the Kentucky Children's Health Insurance Program.

3. Minimum or uniform standards contained in the federal mandate.

   This administrative regulation establishes copayments or similar charges to be paid by Medicaid recipients, their spouses, or parents, under the provisions of Section 1916 of Title XIX of the Federal Social Security Act, 42 U.S.C. sec. 1396o.

4. Will this administrative regulation impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate?

   This administrative regulation does not impose stricter requirements, or additional or different responsibilities or requirements, than those required by the federal mandate.

5. Justification for the imposition of the stricter standard, or additional or different responsibilities or requirements.

   The amendment to this administrative regulation is necessary to control the rising costs of prescription drugs and other services covered by the Medicaid program, thereby maintaining the financial viability of the Department for Medicaid Services.